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**A. COORDINATION OF BENEFITS**

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under health insurance, the WMAP reimburses that portion of the allowable cost remaining after all other health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report." Refer to the claim form completion instructions in Appendix 4 of this handbook for health insurance indicator codes.

**B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT**

**Dual Entitlees**

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient has Medicare and Medicare has denied the service, a Medicare disclaimer code must be indicated on the claim. Refer to the claim form completion instructions in Appendix 4 of this handbook.

**Billing for Medicare Noncovered Refractions**

The refraction portion of a comprehensive vision exam is not paid by Medicare, nor can Medicare forward it to the WMAP for payment. However, refractive services for dual-entitlees which are not covered by Medicare are reimbursable by the WMAP.

In order to obtain Medical Assistance reimbursement for refractions for dual entitlees, providers must do the following:

- Complete and submit a claim to Medicare (using standard Medicare billing procedures) for the comprehensive exam; including the information necessary for all crossover claims. Medicare will cross over the claim to EDS for coinsurance and deductible;
- Complete and submit a HCFA 1500 claim form directly to EDS for Medicare noncovered refractive services;
- Indicate "M-8" ("Not a Medicare Benefit") in element 11 of the HCFA 1500 claim form; and
- Indicate procedure code 92015 in element 24D.

**C. QMB-ONLY RECIPIENTS**

Qualified Medicare Beneficiary-only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and deductible for Medicare-covered services. (Since Medicare covers some vision services, claims submitted for QMB-only recipients are reimbursed for Medicare-covered services.) Refer to Section V of Part A of the WMAP Provider Handbook for instructions on how to identify QMB-only recipients.

**D. BILLED AMOUNTS**

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient. Providers must bill for materials not covered under the State Purchase Eyeglass Contract (SPEC) at actual wholesale cost.

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**D. BILLED AMOUNTS**  
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The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the payment allowed by the WMAP.

Providers should refer to Appendix 4 of this handbook for complete claim form completion instructions.

**E. ORDERING THROUGH STATE PURCHASE EYEGLASS CONTRACT (SPEC)**

**Order Form Requirements**

Order forms submitted to the SPEC contractor by mail or FAX must include:

- The date of order.
- The name, address, and eight-digit Medical Assistance provider number of the dispensing provider.
- The name, address, birthdate, sex, and complete 10-digit Medical Assistance identification number of the recipient.
- A copy of the approved prior authorization request form for all services requiring prior authorization.
- All other pertinent prescription detail.

Please make certain that all information is accurate and legible to ensure that orders are processed correctly and in a timely manner.

**Ordering SPEC Frames or Temples**

The name of the contracted frame or temple(s) must be specified on the order form submitted to the SPEC contractor.

**Ordering SPEC Lenses**

The complete lens formula of the contracted lenses must be specified on the order form submitted to the SPEC contractor.

Recipients must have a current Medical Assistance identification card for all orders submitted, including orders for replacement parts. The recipient must be eligible on the date of order. Orders may not be backdated prior to the date the recipient is seen by the dispensing provider.

All orders must be submitted to the SPEC contractor in writing or by FAX. No telephone orders are accepted. Order forms must be signed by the dispensing provider or an authorized representative.

Orders for managed care program enrollees should be handled according to the terms of the managed care program contract.

**F. NON-CONTRACTED MATERIALS**

**Ordering Non-Contracted Lenses and Frames**

All non-contracted materials require prior authorization. Orders for prior authorized non-contracted materials may be placed with any vendor of the provider's choice, and do not have to be obtained through the SPEC contractor. Refer to Appendices 2 and 3 of this handbook for a list of lenses and frames provided by the SPEC contractor.

**Billing for Non-Contracted Lenses and Frames**

Claims for non-contracted materials must indicate procedure codes V2799 ("non-contracted materials") or W8190 ("dispensing non-contracted materials, and other miscellaneous services") in element 24C of the HCFA 1500 claim form.

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**G. BILLING FOR EVALUATION AND MANAGEMENT PROCEDURE CODES AND CONSULTATIONS**

**Evaluation and Management Procedure Codes**

Claims submitted by optometrists for the highest level evaluation and management procedure codes and unlisted medical procedures (92499) require documentation describing the procedure performed. All claims for these procedure codes must be submitted on paper claims. The provider must write "See Attached" in element 19 (Reserved for Local Use) of the HCFA 1500 claim form and attach additional documentation justifying the level of service billed. This documentation may be in the form of a history and physical exam report or medical progress notes. The documentation must be sufficient to allow the WMAP medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for these medical procedures which do not have sufficient documentation attached to the claim, or for which the documentation does not substantiate the complex level of medical practice being billed, are denied. Refer to Appendix 1 of this handbook for procedure codes requiring documentation.

**Other Evaluation and Management Services**

Evaluation and Management CPT procedure codes in the ranges 99201-99285 and 99301-99353 may be billed only when the patient encounter does not include a surgical procedure code. If a surgical procedure is performed, the provider is reimbursed on the basis of the procedure performed, not on the basis of an evaluation and management visit.

**Consultations**

Claims for consultations must indicate the referring physician's name in element 17, and the referring physician's UPIN number, WMAP provider number, or license number in element 17a of the HCFA 1500 claim form.

**H. BILLING FOR PROCEDURES PRICED AT PRIOR AUTHORIZATION**

Claims for procedures which are priced at prior authorization must be submitted on the HCFA 1500 claim form with:

- a quantity of "1" for each item; and
- the specific modifier from element 15 on the approved PA/RF on the claim form when billing for procedures which are assigned a modifier.

Refer to Section III of this handbook for information on procedures priced at prior authorization.

**I. BILLING FOR UNLISTED PROCEDURE CODES**

Claims for unlisted procedures (92499) require documentation describing the procedure performed. The provider may use element 19 (Reserved for Local Use) of the HCFA 1500 claim form, if the procedure can be clearly described in a few words. If this space is not sufficient, providers should write "See Attached" in element 19 and attach additional documentation. This documentation may be in the form of a history and physical exam report or medical progress notes. The documentation must be sufficient to allow the medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for unlisted medical procedures which do not have documentation either on the claim or attached to the claim are denied.

**J. LABORATORY TESTS**

**Laboratory Tests**

Optometrists and ophthalmologists may be reimbursed for laboratory tests billed as a "complete" procedure or for the professional component only. A complete lab test includes both the professional and technical components. A vision provider may not be reimbursed for the technical component of a laboratory test only.

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**J. LABORATORY TESTS**

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**Laboratory Test Preparation and Handling Fees**

If an optometrist or ophthalmologist performs both the professional and technical components of a laboratory test, the vision provider is reimbursed for the complete procedure. In this instance, a handling fee is not paid.

If a vision provider obtains a specimen and refers it to an outside laboratory for analysis or interpretation, the outside laboratory is reimbursed for the complete procedure. The vision provider may bill only for a handling fee using the handling fee procedure code.

Additional limitations on billing handling fees are:

1. One lab handling fee is paid per provider, per recipient, per outside laboratory, per date of service, regardless of the number of specimens sent to the laboratory. One handling fee is paid only when "yes" is indicated for outside laboratory in element 20 of the HCFA 1500 claim form.
2. When billing handling fees for specimens sent to two or more laboratories for one recipient on the same date of service, indicate the number of laboratories in the units field in element 24G and the total charges in element 24F of the HCFA 1500 claim form.
3. Claims for a lab handling fee which do not have "yes" checked for outside lab in element 20 of the HCFA 1500 claim form are denied.

Clinical interpretations of lab tests are not separately billable, since interpretations are reimbursed within the payment for the recipient's visit.

**K. CLAIM SUBMISSION**

**Paperless Claim Submission**

EDS encourages submission of claims on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Claim processing statistics demonstrate that providers submitting electronically reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS  
Attn: EMC Department  
6406 Bridge Road  
Madison, WI 53784-0009  
(608) 221-4746

**Paper Claim Submission**

Paper claims for vision care services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions can be found in Appendices 4 and 5 of this handbook.

Paper claims for vision care services submitted on any form other than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.  
Post Office Box 1109  
Madison, WI 53701

(608) 257-6781 (Madison area)  
1-800-362-9080 (toll-free)

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**K. CLAIM SUBMISSION**  
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Completed paper claims submitted for reimbursement must be mailed to the following address:

EDS  
6406 Bridge Road  
Madison, WI 53784-0002

**Submission of Claims**

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing appeals can be found in Section IX of Part A of the WMAP Provider Handbook.

**L. DIAGNOSIS CODES**

All diagnoses must be from the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

Refer to Appendix 10 of this handbook for a listing of frequently used diagnosis codes for vision care services.

**M. PROCEDURE CODES**

HCFA Common Procedure Coding System (HCPCS) codes are required on all HCFA 1500 claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes, their descriptions and allowable modifiers for vision services are included in Appendix 1 of this handbook.

**N. MODIFIERS**

Procedure code modifiers may be used to indicate that a service or procedure has been modified by a specific circumstance relative to a procedure performed. A maximum of two valid modifiers may be used for each procedure code. Refer to Appendix 1 of this handbook for a list of allowable procedure codes and modifiers. Only those modifiers listed in this handbook are recognized by the WMAP for vision services. Refer to the Current Procedural Terminology, Fourth Edition (CPT-4) for a complete description of allowable modifiers.

**O. FOLLOW-UP TO CLAIM SUBMISSION**

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures